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Joint Standing Committee on the
National Disability Insurance Scheme
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Parliament House
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27 February 2017

Re.: Inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition

The Mental Health Coordinating Council (MHCC) is the peak body representing community-managed organisations (CMOs) in NSW. Our members deliver a range of psychosocial rehabilitation and disability support programs and services to people affected by mental health conditions. These include National Disability Insurance Scheme (NDIS) funded services for people with psychosocial disability.

MHCC work in partnership with State and Commonwealth governments, and the public, community and private sectors in order to effect systemic change. We also manage and conduct collaborative research and sector development projects on behalf of the sector. MHCC Learning & Development is a widely respected registered training organisation delivering nationally accredited mental health training and professional development courses to the sector.

We understand that as part of your committee's inquiry into the implementation, performance and governance of the NDIS, you will inquire into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition. MHCC welcomes this activity and the opportunity to provide comment.

MHCC have worked since 2011 to understand personalised funding approaches as these relate to people with mental health conditions.[1] MHCC worked in partnership with the Mental Health Commission of NSW between June 2013 and 2016 in the NSW NDIS trial site in the Hunter to explore and understand the experiences of people with psychosocial disability and those that provide services and supports to them. The findings of the *NSW NDIS and Mental Health Analysis Partnership Project* inform this submission along with MHCCs other NDIS and mental health related local, state and national experiences.

More details about the experiences and findings of the project are available in the following publications:

[1] Mental Health Coordinating Council (2011). *Self-Directed Funding and the Community Managed Mental Health Sector: Opportunities and Challenges.*

- Attachment 1 - MHCC (2016). *The National Disability Insurance Scheme (NDIS) and Mental Health in NSW – Navigating the NDIS: Lessons Learned through the Hunter Trial.*

MHCC developed this to support local communities in NSW to prepare for entry into the NDIS, including supporting people with high levels of psychosocial disability to access the scheme.

- Attachment 2 - MHCC (2016). *The National Disability Insurance Scheme (NDIS) and Mental Health in NSW: Guideline for Establishing a Local NDIS Community of Practice to Enhance Learning and Sector Reform.*

MHCC developed this to encourage local community organisations in NSW to establish an NDIS Mental Health Community of Practice to enhance learning arising from NDIS implementation and mental health sector reforms.

MHCC also informed this submission through consultation occurring at a Member's Meet Up Forum held 9 February.

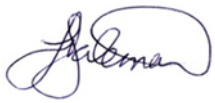
MHCC is a founding member of Community Mental Health Australia (CMHA). CMHA is an alliance of eight state and territory community sector mental health peak bodies. Together we represent more than 800 CMOs delivering mental health and related services nationally. CMHA have integrated MHCC feedback to into their national submission. Nevertheless, MHCC wish to emphasise some key issues from a NSW perspective in this separate submission.

MHCC also submits the following national NDIS and mental health workforce scoping study that demonstrates profound NDIS impacts and makes recommendations for addressing them:

- Attachment 3 - CMHA (2015). *Developing the Workforce: Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Paper Project.* Sydney: MHCC.

The opportunities and challenges presenting through NDIS implementation and other parallel mental health reforms are profound. This includes potential for more than 6,000 people living with mental health conditions – as well as their families/carers and organisations/workers that provide services and supports to them – to have their lives disrupted through reduced access to services and increased risk of psychiatric crisis. MHCC is supportive of the inclusion of people with psychosocial disability within the NDIS but wish to see tighter cross government accountabilities in the mental health space. We also wish to acknowledge the steep learning curve that all various stakeholders have been on as this relates to the NDIS and health/mental health interface and that learning about this will continue to occur for years to come.

MHCC thanks the government for providing this opportunity to provide comment in response to the inquiry. Please contact either me or Tina Smith (Senior Policy Officer, Sector Development: tina@mhcc.org.au) for further information about this submission.



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a) The eligibility criteria for the NDIS for people with a psychosocial disability

Eligibility and access

At 30 June 2016, the Hunter trial site had 1,022 participants with a primary psychosocial disability. In the Nepean Blue Mountains early launch site for young people, there were just 22 participants with a primary psychosocial disability. This considerable NDIS and mental health experience is more extensive than these numbers suggest including, but not limited to, people with other disabilities and mental health issues.

NDIA report that at the end of June 2016, 78% of people with primary mental health conditions making an NDIS access request are eligible by the NDIA. The context of this statistic requires clarity as MHCC understands that some people with mental health conditions who have difficulty navigating sometimes complex NDIS access processes are categorised in NDIA data collections as 'choosing not to apply' or 'withdrawing their application'. The government must also consider outcomes for these people when considering access statistics.

MHCC supports he National Mental Health Commission's recommendation to establish clear benchmarks for NDIS eligibility as a matter of urgency. Benchmarks allow for greater objectivity in evaluation of eligibility and access.

No clear benchmarks have arisen from either trial or the early stages of transition despite the NDIS Act 2013 including guidance on eligibility to access an individually funded support package. MHCC's experience in the Hunter are of little consistency in who was able to, and not able to, access the NDIS. Eligibility is still a difficult thing to discuss with people thinking about making an 'access request' (i.e., to say that you must be very disabled and supply lots of evidence of this as this is not consistent with notions of recovery despite the NDIS being foundationally about 'choice and control'). There is also great variability in the range of plans developed for participants' with similar support needs.

The NDIA Mental Health Sector Reference Group is developing 'reference packages' that may provide benchmarks for access and planning. The NDIA might use treatment related measures like the Health of the Nations Outcome Scale (HoNOS) and Life Skills Profile (16 item; LSP-16) for this purpose. This is a concern because these tools focus on the level of psychiatric symptoms a person may experience and not functional assessment of impairment/disability. Symptoms and impairment do not always correlate. A functional benchmark tool, such as the World Health Organisation Disability Assessment Scale (WHODAS) is preferred.

Indeed, some people do not frame the experience of their mental health condition as either an illness or a disability but are none-the-less very impaired and need support. MHCC attended a meeting last December where a NDIS National Access Team member indicated that diagnostic and treatment information are a requirement for a person with mental health issues to access the NDIS. This information can be useful evidence of illness/disability however, is not a requirement of the NDIS Act, which focuses on impairment/disability. Diagnosis does not demonstrate functional impacts. Some people will not consider the NDIS for support if a diagnosis and/or treatment are a pre-condition of access.

MHCC was invited to participate on the NDIA's 'Operational Access Review for Psychosocial Disability Project' which commenced November 2014 (i.e., to identify practices to enhance our understanding of eligibility and access). The review produced numerous NDIA endorsed recommendations across five themed-based topics including:

- Access (for funded supports)
- Early Intervention

- Language, Processes, Products and Narrative
- Engagement and Outreach, and
- Population Data.

NDIA Mental Health Sector Reference Group meeting 'Communiques' indicate that some actions are being taken forward within the NDIA and others elsewhere but the complete findings and recommendations of this review are not public.

Concerns about eligibility and access also include low clarity about the early intervention pathway into the NDIS for people of any age (Section 25 of the NDIS Act) where a first/early onset mental health condition has the potential to be very disabling.

The initial National Institute of Labour Studies (NILS) NDIS evaluation notes issues about eligibility for people with psychosocial disability and these continued in their second report. They also note concerns about NDIA staff education being insufficient in working with people with complexities, including psychosocial disability. Workers need specific skills to work with people with mental health conditions and complex health and social issues including for the purposes of determining NDIS access and the planning of services and supports.

b) The transition to the NDIS of all current long and short term mental health Commonwealth Government funded services, including the Personal Helpers and Mentors services (PHaMs) and Partners in Recovery (PIR) programs, and in particular; whether these services will continue to be provided for people deemed ineligible for the NDIS

Commonwealth mental health program impacts

In total, MHCC estimates that we are looking at a minimum of 6,000 people with mental health conditions who currently benefit from Commonwealth mental health programs in NSW being potentially disadvantaged through NDIS implementation.

There has been no sector wide evaluation of this in NSW due to the very large numbers of Commonwealth mental health program clients across multiple organisational and geographic locations. Some organisations delivering these programs have audited their client caseload and report that only 30% may access NDIS. While Hunter NDIS trial site experience demonstrates that this percentage seems to be growing with time, experience and an increased understanding of the evidence required to support access is needed.

MHCC has cautiously calculated Commonwealth program client NDIS ineligibility and further background information is below:

- The 6,000 estimate allows for 80% of PIR clients and 30% of PHaMS clients accessing the NDIS.
- PIR (NSW capacity of about 7,000 clients in 15 catchments across three years) – NDIS access rates for the Hunter trial site PIR were initially very low at just 20-30%. Over time, these have reportedly increased to about 80%. This required a lot of functional assessment activity by both PIR and the Hunter New England Mental Health Service to gather sufficient evidence to support NDIS access (40 to 60 hours per person). One PIR in Sydney also reported early success with NDIS access and this has required using brokerage funding to engage private occupational therapists to undertake functional assessments across an average of 120 hours of combined functional assessment work. If 80% of all NSW PIR clients do access NDIS funded support this would leave around 1,400 people in need of

another service (this target is likely ambitious if people 'choosing not to apply' or withdrawing their applications' to NDIS are factored in).

- D2DL (capacity unknown; although understood that some capacity indicators were added into recent contracts) – NDIS access rates consistently reported at about 20-30% with this figure growing as people learn about sufficiency of evidence required.
- PHaMS (capacity of about 6,000 per annum as per the 'Community Mental Health Program – Summary Data 2014-15' available on the DSS website: https://www.dss.gov.au/our-responsibilities/mental-health/publications-articles) - access consistently reported at around just 20-30%. If 30% of all NSW PHaMS clients do access NDIS funded support this would leave around 4,200 people in need of another service.
- DSS's Community Mental Health Program Data 2014/15 also informs us that about 8,000 people in NSW benefit from the Commonwealth funded Mental Health Respite: Carer Support (MHR: CS) program which is also in-scope for the NDIS. Whether this is families/carers and/or clients are unclear to MHCC. NDIS impacts on this program in the trial site have been difficult to ascertain as this program site in Newcastle was small and did not commence until 2015.

The lack of access to data outside of and/or across state and Commonwealth government departments to help all stakeholders manage change occurring through NDIS implementation and other mental health sector reforms implemented through Primary Health Networks is a major issue.

MHCC wrote to the NDIA CEO about our concerns in October 2016 and this correspondence included a request access to data: http://www.mhcc.org.au/media/85835/bowen_ndia_ndis_nsw_letter_20161024.pdf.

The NDIA has since replied seeking permission to table our letter for discussion with DSS, the Commonwealth Department of Health and the NDIS Actuary, as the issues described are broader than just the NDIA. MHCC has agreed to this occurring there and elsewhere, as required.

Close examination of this eligibility and access data is required that is publically accountable. MHCC is now hearing about increases in disadvantage where Commonwealth mental health program clients are found ineligible for the NDIS. This is because there are few other services to direct them to and directions for the 'guarantee of service' for Commonwealth clients under 65 years lack clarity. It seems that Commonwealth mental health clients ineligible for NDIS will no longer receive a service unless this is from within ILC or mainstream services. For NSW, mainstream means mental health treatment, rehabilitation and/or support services provided and/or funded by the Ministry of Health (MoH).

c) The transition to the NDIS of all current long and short term mental health state and territory government funded services, and in particular; i .whether these services will continue to be provided for people deemed ineligible for the NDIS

Access to NSW Health and other 'mainstream' programs for people ineligible for NDIS

NSW is not currently indicating it will withdraw these programs as the NDIS scales up but they will not be sufficient to address unmet population mental health need for people ineligible for an NDIS individual funded package. Furthermore, the NSW MoH program focus increasingly aligns to the needs of people most at risk for psychiatric hospitalisation.

The NSW MoH continues to fund mental health programs delivered by the community sector. This is a mixture of discrete program streams introduced from around 2000 onwards, 'ad-hoc' grants and Ministerial Grants. These complex arrangements are currently undergoing reform through the 'Partnerships for Health' initiative (including the introduction of contestable tendering). The state government states it intends to rationalise and grow community sector delivered programs over time.

Current NSW Ministry of Health programs are:

- The Housing and Accommodation Support Initiative (HASI)
- Recovery and Resource Services Program (RRSP; being subsumed through HASI retendering with a shift to more flexible individualised 'care packages')
- Family and Carer Mental Health Support Program.

The NSW Ministry of Health is establishing the following new programs:

- Enhanced Adults Community Living Supports - increase the level of community living supports to help a further 500 adults across NSW recover and transition to a quality life in the community (HASI enhancement in the direction of individual and flexible funding approaches)
- Pathways to Community Living Initiative – this is a coordinated state-wide approach to supporting 430 people with enduring and serious mental illness who have been in hospital for more than twelve months to, wherever possible, re-establish their lives in the community. The initiative is part of the NSW government's commitment to strengthen mental health care in NSW by developing effective community-based residential care and support options for people experiencing long stays in mental health inpatient units.

Different states are having different experiences in this regard. For example, NSW and Victoria are at different ends of the spectrum with regard to state governments growing or withdrawing from the provision of psychosocial rehabilitation and recovery support services in the current reform environments. Even with the NSW MoH growing as opposed to withdrawing services funded through the community sector the potential impact of the loss of the Commonwealth mental health programs, which have been around for 10 years, will be substantial.

d) the scope and level of funding for mental health services under the Information, Linkages and Capacity building framework

ILC framework development

A quarantined mental health spend is required that is cognizant of the loss on Commonwealth mental health programs.

The 'cohort-focused delivery' and 'delivery by people with disability, for people with disability' (i.e., consumer run services) focus areas allow for the possibility of targeted mental health programs. MHCC's read of the funding guidelines for the $13.1M National Readiness Funds made available in 2016/17 is that there is an insufficient allocation across all disability types. Indeed, the five year planned allocation is likely insufficient against the intentions and planned efficiencies of the NDIS.

There is no quarantined ILC mental health specific allocation and, if there were, it would not come close to replacing the Commonwealth mental health programs that are scheduled to be lost to the NDIS.

The role of ILC Local Area Coordinators (LACs; i.e., the 'outsourced' LAC roles and functions that Uniting and SVDP provide in NSW) were in NDIS transition planning have been heavily focused on the 78,000 transitioning clients of the NSW Department of Family and community Services (FaCS) Department of Ageing, Disability and Homecare (ADHC). This is because ADHC plans to close by July 2018. For historical reasons, few ADHC clients have primary psychosocial disability but many struggle with mental health conditions that often co-exist with their intellectual, physical and/or sensory disability. LACs also assist the transition of Commonwealth funded mental health programs, however, the priority of these clients lacks clarity in NSW.

LACs capacity to undertake information, referral and community development work reduces when their priority is NDIS transition planning and as opposed to the community development foundation of the ILC. This situation enhances the risk to NDIS ineligible Commonwealth clients.

Most large organisations that provide service delivery to people with mental health conditions indicate that they are considering tendering for the current National ILC Sector Readiness Grants through building upon and/or establishing an evidence base for programs that they already run. From a mental health perspective there appear to be opportunities such as:

- Consumer delivered services and programs (i.e., including but also moving beyond peer work), and
- Prevention, promotion and early intervention (PPEI) services.

The situation for understanding where mental health PPEI practice sits in an NDIS environment with parallel mental health sector reforms through PHNs is particularly complicated. This is because the NDIS 'Applied Principles' state that rehabilitation is a health/mental health mainstream responsibility, however, psychosocial services and supports that build individual capacity and prevent psychosocial disability by intervening early are known evidence based practice.[2]

At a 9 February 2017 MHCC Member Meet Up Forum where we consulted on this NDIS submission we were reminded that many frontline workers are still striving to understand what an NDIS individual funded package is let alone the ILC which is still in a developmental place. The government must mitigate risk to Commonwealth clients during development of the ILC and

[2] MIND and the University of Melbourne (2016). *Effective, evidence-based psychosocial interventions suitable for early intervention in the National Disability Insurance Scheme (NDIS): promoting psychosocial functioning and recovery.*

implementation of other mental health reforms by operationalising continuity of service arrangements.

With a limited amount of funding available and no quarantining of the psychosocial disability and/or mental health budget this will be an intensely competitive ILC tendering field. MHCC recommends monitoring the mental health/psychosocial disability related outcomes of the tender (i.e., both applications made and granted nationally and by jurisdiction).

e) The planning process for people with a psychosocial disability, and the role of primary health networks in that process

Planning and review process

Recovery-oriented and trauma-informed approaches to planning and review for NDIS participants with psychosocial disability are required.

People with mental health conditions usually require considerable pre-planning activity and /or a supporter to negotiate the planning and review process. As with access, people with mental health conditions can be overwhelmed and/or distressed by the planning and review processes. Telephone based planning does not work in supporting people with mental health conditions and several face-to-face meetings may be required to complete a plan. NDIA's 'My First Plan' approach disadvantages NDIS eligible Commonwealth program clients who are sometimes unfunded against their needs in comparison to NSW FaCS/ADHC clients who are also the priority in NSW transition. MHCC member advice is that the LAC planning roles(through SVDP and Uniting) are not well skilled for mental health/psychosocial disability practice and that acquiring this skill set has been challenged by the ambitious transition targets that they are being asked to meet.

Neither NDIA staff nor their 'Partners in the Community' (i.e., the outsourced LAC roles and functions) are using recovery-oriented and trauma-informed practice approaches. MHCC is pleased to have contracted with the NDIA for our 'Capacit-e' suite of e-learning resources now available to NDIA staff and people in LAC roles. Trauma informed practice workforce development could build on this foundation, not just for people with psychosocial disability but also for use with other people with a range of complex health and social needs.

The experience of having a mental health condition can be traumatising. Many people that have difficulty managing a mental health condition also report adverse childhood experiences. Too many are reporting contact with NDIA NDIS eligibility, access and planning processes to be challenging to navigate and re-traumatising.

The role of PHNs in NDIS planning processes lacks clarity. The NDIA Mental Health Sector Reference Group Communique advises that the NDIA hosted a meeting with PHN CEOs occurred in October 2016 toward beginning to explore this interface. Work to understand the interface between PHN's and the NDIS will be progressed in 2017. This area of work is included within the NDIA Mental Health Work Plan for 2016/17 (this document is also not public).

The Commonwealth Department of Health has instructed PHNs that they will not deliver psychosocial services. The PHNs role seems to be more about assessment, and treatment (i.e., for the purpose of diagnosis, the prescription of medications and psychological therapies, including low intensity approaches, under a 'stepped care' approach). A cross government framework to measure outcomes of a strengthened interface between the NDIA, PHNs and mainstream health/mental health services – both government and non-government – needs to be identified. MHCC hopes that he PHN pilot/s evaluation/s will demonstrate some emerging innovations.

MHCC has not observed a lot of PHN and NDIS interface as yet in either the Hunter trial site or elsewhere in NSW although there has been great interest where a PHN was previously a Medicare Local leading a PIR initiative. This includes one PHN previously noted who is also a PIR lead agency reportedly funding private occupational therapists to undertake functional assessments.

f) Whether spending on services for people with a psychosocial disability is in line with projections

NDIS spending on services for people with a psychosocial disability

There needs to be a greater transparency for spending on services for people with psychosocial disability so stakeholders can undertake accountabilities in line with projections.

To answer this question MHCC would need better access to high quality NDIS and mental health/psychosocial disability data.

Productivity Commission (2011) projections were for 13.9% of participants to have primary psychosocial disabilities and both the Victorian/Barwon and NSW/Hunter trial sites are in proximity to this target at 12.2% and 14.2% respectively. These two states have more similar trial histories compared to other states and territories thus allowing comparison.

However, these percentages do not translate to total available dollars for the 57,000 (now 64,000) people with psychosocial disability or the full $1.8B+ intended expenditure at full national transition of the NDIS. However, MHCC believes that there has to date been an under spend. The nature of the trial and transition in different state and territories may have contributed to this but expenditure has little transparency apart from average package costs. It is important that there is not a reduction in either the quantum or effectiveness of community managed psychosocial rehabilitation and disability support services through NDIS rollout.

Furthermore, people with psychosocial disability are beginning to report feeling like they have less choice and control in the NDIS environment (NILS, 2015). In addition, we are not yet seeing the full effects of the impacts of the new approach to ‘coordination of supports’ introduced in late 2015. The new coordination of supports items may help NDIS participants challenged to spend out on their full package to better do so. However, this requires a mature market with services and supports – including appropriate workforce skills/qualifications to support people’s rehabilitation and recovery- to be available to purchase.

The NSW NDIS Market Position Statement (2016) does not consider the market for psychosocial disability support. Market readiness support to date has focused on traditional disability service providers.

g) The role and extent of outreach services to identify potential NDIS participants with a psychosocial disability; and

Availability of outreach services to identify potential NDIS participants

PIR needs to continue in some form to maintain an outreach and engagement service.

If the NDIS subsumes PIR as planned, then there will be no targeted outreach and engagement services for people with mental health conditions, whether NDIS participants or not. Providers in the Hunter trial site including but not limited to PIR report an average of 40-60 hours of functional assessment work to support NDIS access. These activities are NDIA funded at only up to $750.

Many people with mental health conditions require considerable hours of outreach, engagement and functional assessment activities over an extended time to consider and make an NDIS access request. People with mental health conditions can be overwhelmed and/or distressed by the level of complexity that can sometimes accompany making an access request and thus 'choose not to apply' or 'withdraw their access request'.

The Outreach and Engagement Working Group of NMHSRG National Operational Access Project findings identified considerable issues related to access for people with complex needs, including many with mental health conditions. As previously noted, the recommendations related to engagement and outreach have not been made public including a comprehensive list of what is being taken forward by the NDIA and/or elsewhere (Commonwealth DSS and/or DHS? State and territory governments?).

MHCC understands that NDIA (and/or DSS?) funded 'hard to reach' projects are underway in Victoria and Western Australia. Little information about the learning arising is available about these projects.

h) The provision, and continuation of services for NDIS participants in receipt of forensic disability services

NDIS and forensic disability services

People with a mental health condition are excluded from the forensic disability service in NSW (i.e., the Statewide Disability Services at the Department of Justice; Community Justice Program is the community forensic disability service). The NDIA in the Hunter at one time had indicated that a forensic project was occurring in the context of the deinstitutionalisation the Kanangra Licensed Residential Facility in Morisset (the people residing there have very complex needs and that typically include intellectual disability and/or acquired brain injury).The outcomes of this activity are unknown.

Many clients block funded under the Community Justice Program also have mental health issues and we understand that in the process of transitioning to the NDIS they have lost access to psychological therapies by organisations previously supporting there complex needs in this way.

Kanangra is adjacent to the Hunter New England Mental Health Psychiatric Hospital in Morisset (this is a long-term extended care facility). Some people with mental health conditions and forensic legal status have returned to community living from the psychiatric hospital at Morisset using NDIS funding.

There is great concern in NSW about what will happen for people with complex needs in an NDIS environment that does not have the allied health skills and expertise built up over many years from within ADHC that will cease operations in June 2018.

MHCC members advise that in the event of an NDIS participants' death or incarceration there is an immediate cessation of funding. This greatly disadvantages service providers who typically undertake considerable activities around such major life transitions.

i) any related matter.

Quality and safety

The recently released Quality and Safeguarding Framework for the NDIS is not sufficiently inclusive of the unique needs of people with mental health conditions who may at times be subject to substitute decision making under state and territory mental health legislation. The Framework is a nationally consistent system of protections for NDIS participants. It will replace State and Territory protections at full NDIS implementation in 2018. The wholesale dismantling of existing community sector mental health services, both Commonwealth and in some states, will not result in quality and safety of services for people with mental health conditions whether NDIS participants or not.

Governments need to place a much more dedicated focus on the market, providers and pricing, and workforce to maintain and grow an efficient and effective psychosocial rehabilitation and recovery/disability support sector (i.e., the 'market' for NDIS participants with mental health conditions). CMHA's 2015 NDIS workforce report elaborates upon these and other workforce related matters (Attachment 3).

NDIS mental health workforce impacts

Governments expect the NSW NDIS workforce to grow from an estimated 24,750 - 30,250 FTE in 2016 to 48,400 - 59,200 FTE in 2019. The absence of sector specific strategies to enhance recruitment and retention, coupled with uncertainty arising about the future of Commonwealth mental health programs, is resulting in higher than usual staff turnover and employment of less skilled/qualified workers. It has been increasingly challenging to maintain a Certificate IV or equivalent standards agreed to be the sector training standard for some years.

Workforce considerations such as recruitment, training, retaining, competency, and quality need consideration. NDIS pricing is not sufficient for a suitably qualified workforce to undertake psychosocial rehabilitation and recovery support skills.

CMHA is pursuing Workforce Innovation Funding to progress some of the recommendations of the NDIS and mental health workforce scoping study as this relates to achieving a more flexible workforce beyond casualization. However a key recommendation, to undertake community mental health sector role mapping (i.e., skills, qualifications and pricing) and identify appropriate supports pricing, also needs to be progressed in collaboration with mainstream health/mental health service providers.

Mainstream health/mental health sector accountabilities

High-level cross-governmental accountabilities are required to ensure that the opportunity of the NDIS and related mental health reforms are maximised.

As noted in the Productivity Commission's NDIS Issues paper (2017), there is the potential for service gaps to emerge at many points along the intersection between the NDIS and mainstream services. However, particular concerns have been raised about the interface between the NDIS and mental health services. It is vital that further analysis is undertaken in relation to:

- How the full rollout of the NDIS will affect how mental health services are provided, both for those who qualify for support under the scheme and those who do not?
- What, if anything, needs to be done to ensure the intersection between the NDIS and mental health services outside the scheme remains effective?
- How the existing partnerships between public mental health services and community sector providers focused on shared treatment and support of individuals will be sustained in an NDIS environment of multiple and varied providers?

The draft Fifth Mental Health Plan provided little detail on how the NDIS was shaping mental health reforms or vice versa. This must occur or there will be many unintended consequences including potentially large numbers of people with mental health conditions and their families/carers missing services. In addition to these human costs, there is an ongoing high risk of cost shifting between government departments and there continuing to be no overarching framework or accountability for community mental health development despite policy directions and evidence based practice supporting this. Health and Social Services Ministers at state and national levels must become more engaged with NDIS transition to pre-empt negative impacts on the mental health service system and maximise opportunities presenting.